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1.0000 Definitions

The following terms and definitions shall apply to reimbursement for inpatient hospital services.

a. "Admission" means the condition of entry into a hospital for the purpose of receiving inpatient medical treatment.

b. "Allowable cost" means the Medicare definition of allowable cost in effect for a hospital's fiscal year end.

c. "Border cities" mean those communities outside of the state of Kansas but within a 50 mile range of the state border.

d. "Cost outlier" means a general hospital inpatient stay with an estimated cost which exceeds the cost outlier limit established for the respective diagnosis related group.

e. "Cost outlier limit" means the maximum cost of a general hospital inpatient stay established according to a methodology specified by the Department for each diagnosis related group.

f. "Day outlier" means a general hospital inpatient stay which exceeds the day outlier limit established for the respective diagnosis related group.

g. "Day outlier limit" means the maximum general hospital inpatient length of stay established according to a methodology specified by the Department for each diagnosis related group.

h. "Diagnosis related groups (DRG)" means the classification system which arranges medical diagnoses into mutually exclusive groups.

i. "Diagnosis related groups (DRG) adjustment percent" means a percentage assigned by the Department to a diagnosis related group for purposes of computing reimbursement.

j. "Diagnosis related groups (DRG) daily rate" means the dollar amount assigned by the Department to a diagnosis related group for purposes of computing reimbursement when a rate per day is required.

k. "Diagnosis related groups (DRG) reimbursement system" means a reimbursement system in the Kansas Medicaid/MediKan Program for general hospital inpatient services which uses diagnosis related groups for determining reimbursement on a prospective basis.

l. "Diagnosis related groups (DRG) weight" means the numeric value assigned by the Department to a diagnosis related group for purposes of computing reimbursement.

m. "Discharge" means the condition of release from a hospital. A discharge occurs when the recipient leaves the hospital or dies. A transfer to another unit within a hospital (except to a swing bed), or a transfer to another general or state operated hospital is not a discharge.

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n. "Discharging hospital" means (in instances of the transfer of a recipient) the hospital which discharges the recipient admitted from the last transferring hospital.

o. "Disproportionate share hospital" means a hospital which has a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in Kansas, or a hospital whose low income utilization rate exceeds 25 percent. A disproportionate share hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid eligible individuals. This does not apply to a hospital whose inpatients are predominantly under 18 years of age or which does not offer nonemergency obstetric services to the general population as of December 21, 1987. In the case of a hospital located in a rural area as defined by the Health Care Financing Administration, Executive Office of Management and Budget, the term "obstetrician" may include any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

p. "Estimated cost" means the cost of general hospital inpatient services provided to a recipient which is computed using a methodology specified by the Department.

q. "General hospital" means an establishment with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for patients.

r. "General hospital group" means the category to which a general hospital is assigned by the Department for purposes of computing reimbursement.

s. "General hospital inpatient beds" means the number of beds as reported by the general hospital on the hospital and hospital health care complex cost report form excluding those beds designated as skilled nursing facility or intermediate care facility beds. For hospitals not filing the hospital and hospital health care complex cost report form the number of beds shall be obtained from the provider application for participation in the Kansas Medicaid/Medikan Program form.

t. "Group reimbursement rate" means the dollar value assigned by the Department to each general hospital group for a diagnosis related group weight of one.

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u. "Length of stay as an inpatient in a general hospital" means the number of days an individual remains for treatment as an inpatient in a general hospital from and including the day of admission, to and excluding the day of discharge.

v. "Low income utilization rate" means the sum of (1) the fraction expressed as a percentage, the numerator of which is the sum for a period of the total revenues paid by Medicaid to the hospital for patient services and the amount of the cash subsidies for patient services received directly from state and local governments, and the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and (2) a fraction expressed as a percentage, the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies (as referred to above in [1]) in the period reasonably attributable to inpatient hospital services, not including contractual allowances and discounts other than for indigent patients not eligible for Medicaid and the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

w. "Medicaid inpatient utilization rate" means a fraction expressed as a percentage, the numerator of which is the hospital's number of inpatient days attributable to patients who for such days were eligible for Medicaid in a period, and the denominator of which is the total number of the hospital's inpatient days in that period.

x. "Metropolitan statistical area (MSA)" means a geographic area designated as such by the United States executive office of management and budget.

y. "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another hospital participating in the DRG reimbursement system.

z. "Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

aa. "Standard diagnosis related group (DRG) amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis related group weight.

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bb. "State-operated hospital" means an establishment operated by the State of Kansas with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients.

cc. "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

dd. "Transfer" means the movement of an individual receiving hospital inpatient services from one hospital to another hospital for additional related inpatient care after admission to the previous hospital or hospitals.

ee. "Transferring hospital" means the hospital which transfers a consumer to another hospital. There may be more than one transferring hospital for the same consumer until discharge.

2.0000 Reimbursement for Inpatient General Hospital Services According to Diagnosis Related Groups (DRGS)

2.1000 Hospital Participation Effective Date

Effective with services provided on or after October 1, 1996, general hospitals will be paid in accordance with the Kansas Medicaid/MediKan Diagnosis Related Groups (DRG) Reimbursement System described in Sections 2.0000 and 3.0000. This does not include state-operated hospitals. State-operated hospitals are discussed in 4.0000.

2.2200 General Billing

Under the DRG Reimbursement System, a hospital may bill only upon discharge of the consumer except as noted in subsections 2.2300 and 2.2400.

2.2300 Transfer Billing

A transferring hospital participating in the DRG Reimbursement System shall submit a bill at the time of transfer even though a transfer is not defined as a discharge. The method of computing reimbursement for a transferring hospital is different from that for a discharging hospital as discussed in subsections 2.5410 and 2.5440.

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2.2400 Interim Billing

An interim bill is a claim which covers less than an entire inpatient stay. A general hospital may, at its option, submit interim billings for an inpatient stay longer than 180 consecutive days with the same DRG reimbursement system on the 180th day and at 180 day intervals thereafter in most cases. The following criteria apply:

a. The first interim bill shall begin with the date of admission, and all subsequent interim billings shall start with the day following the last date of service included on the preceding interim billing. There should be no duplication of days between any two consecutive interim bills.

b. Each interim bill shall include no less than 180 days of continuous inpatient stay with the exception of the following two situations where less than 180 days may have elapsed after the preceding interim bill:

The final bill at the time of discharge:

The combination interim/federal fiscal year end cut-off billing, because on October 1 of each year a new 180 year interim billing cycle will begin.

2.3000 Hospital Grouping

The Kansas Department of Social and Rehabilitation Services shall assign each general hospital participating in the Kansas Medicaid/MediKan Program to one of three groups. The Department shall redetermine hospital group assignments annually. The Department shall notify in writing each general hospital located in Kansas of its group assignment. The cost reports with fiscal years ending on and before December 31 of the previous year shall be used to establish group placement. Effective December 29, 1995, hospitals shall be assigned to groups according to the following method.

a. A general hospital assigned to group one shall be:

1. Located within a metropolitan statistical area in the state of Kansas and have a minimum of 200 general hospital inpatient beds; or
2. Located within the state of Kansas and within 10 miles of a general hospital meeting the criteria set forth in subsection a(1); or
3. Located outside of the state of Kansas or its border cities and have a minimum of 200 general hospital inpatient beds.

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2.3000 (continued)

b. A general hospital assigned to group two shall be:

1. Located within a metropolitan statistical area in the State of Kansas and have less than 200 general hospital inpatient beds, or be located within a metropolitan statistical area in a border city; or
2. Located outside of a metropolitan statistical area in the State of Kansas or its border cities, and have a minimum of 100 general hospital inpatient beds; or
3. Located within 10 miles of a general hospital meeting the criteria set forth in subsections b 1. or b 2. above; or
4. Located outside of the State of Kansas or its border cities with at least 100 general hospital inpatient beds.

c. A general hospital shall be assigned to group three if it does not meet the criteria pursuant to subsections a or b above.

d. A general hospital shall be assigned to group one if it meets the criteria for assignment to both group one and group two.

2.4000 The DRG Reimbursement System Components

The Kansas Department of Social and Rehabilitation Services has used the DRG classification published by Health Care Financing Administration (HCFA) for developing the necessary components of the DRG Reimbursement System. In addition, effective October 1, 1992, the Department has established new DRG classifications for neonatal services as indicated below.

385	Short stay neonates died or transferred (2 day maximum)
386	through 388 No longer used
389	Birth weight > 2000 grams, full term with major problems
390	Birth weight > 2000 grams, full term with other problems
391	Birth weight > 2000 grams, premature or full term, without complicating diagnoses
801	Birth weight < 1000 grams
802	Birth weight 1000 - 1499 grams
803	Birth weight 1500 - 2000 grams
804	Birth weight > 2000 grams, w/ respiratory distress syndrome
805	Birth weight > 2000 grams, premature w/ major problem

After the DRG number reassignments, all these claims became part of the total data base used for the DRG Reimbursement System.

Subsections 2.4100 through 2.4700 provide a discussion of the development of all the system components for use effective October 1, 1996. The discussion flows in the order of the steps performed for the computations involved. For example, the establishment of the data base (Subsection 2.4100) was necessary before cost determination (Subsection 2.4200), outlier claims had to be identified (Subsection 2.4300) prior to separating them out from the data base (Subsection 2.4410).

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2.4100 Data Base

For developing the DRG relative weights, group payment rates, and other system components for use effective October 1, 1996, the Department used as a data base, the Medicaid/MediKan paid claims for services, the two year period ending May 26, 1996. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

- crossover claims (Medicare paid by Medicaid).
- swing bed claims.
- claims paid from psychiatric and rehabilitation hospitals.
- claims paid from out-of-state hospitals.
- claims from transferring hospitals (in case of transfers, only the claims from the final discharging hospitals were included in the data base), except for DRGs 385 and 456.
- adjusted claims (in cases where a hospital resubmitted a claim with corrections, the original claim was excluded from the data base. Only the final paid claim was included).
- claims with unusually low cost data for the given DRG, or other abnormal data.
- interim claims which could not be matched together.

2.4120 Claims Modified Before Including in the Data Base

Interim claims were identified and matched together to result in either a complete stay or a lengthy stay where no discharge had occurred.

2.4200 Determination of the Costs of Claims

The cost of each claim in the data base was determined using the cost data from the respective hospital's cost report, as discussed below.

2.4210 Cost Reports

The Department used the most recently available unaudited hospital cost reports to obtain the cost data for determining costs of claims.

2.4220 Cost Data

The cost data considered for computing costs of claims included education and capital costs. Indirect and direct medical education costs were later removed; however, as specified in Section 2.4240.